FAMILY PLANNING PROGRAM

REVISED 10/1/2019 – CHANGE NO. 10-19

I. Introduction

The Medicaid Family Planning Program (FPP or MAF-D) establishes a system by which the applicant/ beneficiary (a/b) can more easily access family planning services to reduce the number of unplanned pregnancies.

Beneficiaries receiving FPP are "locked" into a 12-month certification period. If the beneficiary reports medical bills, then the caseworker must determine in which 6-month period the deductible is met and authorize Medically needy coverage effective the day the client meets their deductible through the end of that 6-month period.

When evaluating a client for Medicaid coverage, the a/b may choose to not be evaluated for FPP. The a/b must submit this request in writing to the agency prior to disposition of the application.

II. Eligibility Requirements

A. Be a citizen of the U.S. or be an alien who meets the requirements in MA-3332, US Citizenship Requirements or MA-3330 Alien Requirements. An undocumented alien is ineligible for this program.

B. No age restrictions.

C. Be a resident of NC as defined in MA-3335, State Residence.

D. Not be an inmate of a public institution. See MA-3360, Living Arrangements.

E. Not be in an institution for mental diseases. See MA-3360, Living Arrangement.

F. Provide verification of all health insurance coverage for the a/b and assign to the State all rights to third party payments from any such insurance coverage.

G. Furnish the a/b's SSN or apply for a number if the a/b does not already have one or furnish all SSN's which have been used or under which benefits have been received. See MA-3355, Enumeration.

H. Meet income criteria in MA-3306.

I. Must cooperate with Child Support Services if they are a parent/caretaker of a child receiving Medicaid or if the child is 19 or 20 years old, has an existing

support order established before age 18 and is attending primary or secondary school.

III. Determining Eligibility

A. Determine FPP eligibility when:

1. The child turns age 19 and is no longer eligible in another Medicaid program
2. If it is not anticipated that a deductible will be met, or
3. Disability will not be established by application disposition date.

B. Income is at or below 195% of the federal poverty level.

C. Apply MAGI budgeting methodologies to individuals in FPP.

IV. Resources

Do not count resources in determining eligibility for FPP.

V. Identification Card

A Medicaid identification card will be issued for beneficiaries of FPP. The card does not indicate that coverage is limited under this program. It is up to the healthcare provider to check program limitations along with eligibility for each date of service.

While Managed Care does not apply to FPP beneficiaries, the local agency may assist in helping the a/b find a healthcare provider.

VI. Application Processing Standard

The application processing standard is 45 calendar days. Family Planning Program a/b's are subject to the Income and Eligibility Verification System (IVES) requirements and automated matches.

VII. Evaluate Medicaid Eligibility

A. Evaluate for all Medicaid programs, including FPP. If eligible, authorize the a/b in the appropriate category.

For example, if a child turns age 19 in the month of application authorize Medicaid for Infants and Children (MIC) for the application month, provided all other requirements are met. If the child is eligible for FPP beginning with the second ongoing month, authorize FPP through the end of the current 12-month certification period. Evaluate for all other programs, including FPP, in the second month and ongoing maintaining the 12-month certification period.

B. Medically Needy

When an a/b is potentially eligible for Medically Needy, authorize the a/b for Medically Needy only if medical expenses meet the deductible as of the date of application. If the medical expenses meet the deductible as of the date of application, do not key an FPP application.

If the deductible is not met as of the date of application, but the a/b anticipates meeting and is within $300 of the deductible, follow **all** of the instructions below.

1. Key a new application for Medically Needy (MAF-M or MAD-M) and pend for medical bills to meet the deductible, up to six months, if otherwise eligible. If applicant fails to provide medical bills to meet their deductible, by the 6-month deadline, deny the Medically Needy application.

2. If otherwise eligible approve the FPP application, unless the a/b submits, in writing, that they wish to not be evaluated for FPP.

3. When the a/b meets the deductible, authorize the Medically Needy Case effective the date the deductible is met through the end of the current 6-month period. Leave the FPP case active if the deductible is met in the first 6-month period.

4. Follow MA-3315, Medicaid Deductible when the a/b meets the deductible, send the appropriate notices.

C. Medicaid for Adults with Disability (MAD)

When an applicant is applying for Adult Medicaid (MAD) and the local agency is waiting for a Disability Determination Services (DDS) decision, follow all the instructions below:

1. Key a new MAGI application and, if otherwise eligible, approve the FPP application. The exception is when the a/b submits, in writing, that they wish to not be evaluated for FPP.

2. If the applicant is later determined to be disabled by DDS, terminate the FPP case and approve the pending MAD application.

3. If the applicant is found not to be disabled by DDS, deny the MAD application and leave the FPP case active.

VIII. Certification Period

The certification period is 12 months for an FPP ongoing case. The certification period cannot be adjusted to match the family's certification periods for other Medicaid cases due to the 12-month lock in period.

IX. Recertification

Using the ex-parte process described in MA-3421, evaluate for all other Medicaid programs.

X. Change in Circumstance

A. Medicaid changes from FPP to a greater benefit cannot be retroactive.

1. When the change is reported, the caseworker must evaluate the change and take appropriate action on the case within 30 days.

   a. If the change results in a greater benefit other than a deductible, make the change effective the first of the following month.

   b. If the change results in a deductible, make the change effective the date that the a/b meets their deductible using the following steps:

      1) Based on the certification period established for the FPP case, determine in which 6-month period of the 12-month certification period that the 6-month deductible is met.

      2) If the deductible is met in the first 6-month period, leave the FPP case active through the end of the original 12-month certification period.

      3) At the end of that 6-month period conduct an ex-parte review on the medically needy case to determine what action should be taken on the case.

      4) If the deductible is met in the second 6-month period, close the original 12-month FPP Case

      5) Authorize Medicaid, effective the day the deductible is met through the end of that 6-month period and send appropriate notice.

2. When the 2nd medically needy certification period ends, conduct an ex-parte review to evaluate for other Medicaid programs. If the beneficiary is again eligible for FPP only, **authorize a new 12-month FPP certification period.**

3. Do not react to the change when the a/b meets their deductible in the last month of the 12-month certification period after pull check (the workday prior to the last business day of the month) and the Medicaid card will be mailed for FPP.

4. In this situation, complete a new administrative application and evaluate to determine if the a/b can meet the deductible in the next 6-month period.

B. When a change in circumstance is reported, evaluate for all Medicaid programs and request additional information, if needed. Anytime an a/b reports medical bills to meet a deductible, a new Medically Needy application MUST be keyed and evaluated.

1. If there is a change in benefit, either increase or decrease, send appropriate notice to client.
2. If there is no change in the benefit, inform the client using a manual DMA-8110 in NC FAST, via pro forma, with an outcome of continuation.

XI. Covered Services

Advise the a/b that if approved for FPP, the Division of Public Health or health care providers will provide more detailed information about covered services and how to obtain them at the initial family planning office visit. Information also may be obtained from the Division of Health Benefits.

Services included as part of the family planning program include (This list is not all inclusive):

1. Annual family planning exam that includes pap smear and breast exam for women and a testicular exam for men,

2. Counseling and contraceptive supply visits to support the effort to continue a pregnancy spacing plan,

3. Most methods of birth control,

4. Screening and treatment for STI (Sexually Transmitted Infections),

5. Screening for HIV (Human Immunodeficiency Virus),

6. Sterilizations for men and women over age 21.